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**PATIENT COMPLAINT - THIRD-PARTY CONSENT FORM**

PATIENT'S NAME: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

COMPLAINANT NAME: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_

**IF YOU ARE COMPLAINING ON BEHALF OF A PATIENT OR YOUR COMPLAINT OR ENQUIRY INVOLVES THE MEDICAL CARE OF A PATIENT THEN THE CONSENT OF THE PATIENT WILL BE REQUIRED. PLEASE OBTAIN THE PATIENT'S SIGNED CONSENT BELOW.**

I fully consent to my Doctor releasing information to, and discussing my care and medical records with the person named above.

This authority is for an indefinite period / for a limited period only (*delete as appropriate*)

Where a limited period applies, this authority is valid until.....(*insert date*)

Signed ..... (Patient)

Date.....